Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JOE WILKINSON MD
3555 KNICKERBOCKER ROAD
SAN ANGELO TX 76904

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-1028-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was referred to Dr. Wilkinson… for an evaluation of the right third dorsal MCP as well as a 4cm laceration. The patient lacerated his extensor tendon. The insurance carrier Texas Mutual has denied the surgery and pre-op lab for no precertification. I spoke with Desiree Johnson at Texas Mutual on 06-29-2011 at 9:00am and she advised if the surgery is emergent, preauthorization would not be required. I filed the bill for the pre-op lab that was done on 6-27-11, billed amount is $64.00 and surgery that took place on 6-30-11, billed amount is $1191.00 and both bills denied stating Precertification/Authorization/Notification Absent."

Amount in Dispute: $1,255.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. This dispute involves Texas Mutual's denial of payment for surgical treatment provided 6/27/11. Preauthorization was not obtained. Further, the documentation provided by the requestor in the DWC-60 packet does not substantiate an emergency as defined by DWC Rule 133.2."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2011	Professional Services – CPT Code 36415	$15.00	$0.00
June 27, 2011	Professional Services – CPT Code 85027	$24.00	$0.00
June 27, 2011	Professional Services – CPT Code 80051	$25.00	$0.00

June 30, 2011	Outpatient Surgical Services – CPT Code 26410	$1,191.00	$0.00
TOTAL		$1,255.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 requires preauthorization for specific treatments and services.
3. 28 Texas Administrative Code §133.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
4. 28 Texas Administrative Code §133.2, effective July 27, 2008, 33 TexReg 5701, defines a medical emergency.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 25, 2011
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED.

   Explanation of benefits dated October 27, 2011
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 785 – SERVICE RENDERED IS INTEGRAL TO SERVICE REQUIRING PREAUTHORIZATION. PREAUTHORIZATION NOT SOUGHT/APPROVAL NOT OBTAINED FOR THAT SERVICE.

   Explanation of benefits dated November 14, 2011
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
   - 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED.

   . Explanation of benefits dated November 15, 2011
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 785 – SERVICE RENDERED IS INTEGRAL TO SERVICE REQUIRING PREAUTHORIZATION. PREAUTHORIZATION NOT SOUGHT/APPROVAL NOT OBTAINED FOR THAT SERVICE.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION

Issues

1. Did the disputed professional services, CPT codes 36415, 85027 and 80051 and surgical service 26410 require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 (c)(1)(A) and (B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   (A) An emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   (B) Preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   28 Texas Administrative Code §134.600(p)(2) states "Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   28 Texas Administrative Code §133.2 (3) defines "Emergency—Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including sever pain, that the absence of immediate medical attention could reasonably

be expected to result in:

(i) Placing the patient's health or bodily functions in serious jeopardy, or

(ii) Serious dysfunction of any body organ or part."

2. Review of the submitted documentation finds that the requestor did not submit documentation to sufficiently support that the professional services performed on June 27, 2011 and the surgery performed on June 30, 2011 was on an emergency basis as defined in 28 Texas Administrative Code §133.2 (3). Therefore, the disputed services required preauthorization per 28 Texas Administrative code §134.600(p)(2). The requestor did not submit documentation to support preauthorization was obtained. Therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 16, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.